TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
IGOR RAKOVCHIK, DO

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-16-1939

Carrier's Austin Representative
Box Number 45

MFDR Date Received
MARCH 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please note from the attached proof of First Submission to the carrier that you did receive the claim timely and in compliance with **Rule 133.20(b)** and therefore, this claim is subject to having a Complaint filed on the carrier for non-payment."

Amount in Dispute: $818.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "An immediate re-audit of the services in dispute has been requested to allow payment pursuant to the Division's rules and payment policies which is currently still in the audit process."

Response Submitted by: SORM

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 5, 2015	CPT Code 99204 New Patient Office Visit	$247.70	$0.00
	CPT Code 95886 (X2) Needle EMG	$271.16	$0.00
	CPT Code 95910 Nerve Conduction Studies (7-8)	$274.38	$0.00
	HCPCS Code A4556 Electrodes	$25.00	$0.00
TOTAL		$818.24	$0.00

FINDINGS AND DECISION

*This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §134.203, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - 29-The time limit for filing has expired.
   - 937-Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.
   - 243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
   - 5080-Based on the receipt of additional information and/or clarification, we are recommending further payment be made for the above noted procedure code(s).
   - W3-Additional payment made on appeal/reconsideration.

Issues

1. Does a timely filing issue exist?
2. Is the requestor entitled to additional reimbursement for CPT code 99204, 95886 and 95910?
3. Is the benefit for HCPCS code A4556 included in the benefit of another service billed on the disputed date? Is the requestor entitled to reimbursement for HCPCS code A4556?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "29-The time limit for filing has expired."

   Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   The respondent stated that "Review of the previous audit determined that the audits denied payment in error…An immediate re-audit of the services in dispute has been requested to allow payment pursuant to the Division's rules and payment policies which is currently still in the audit process." Therefore, the Division finds that a timely filing issue does not exist.

2. To determine if the requestor is due additional reimbursement for CPT codes 99204, 95886 and 95910 the Division refers to 28 Texas Administrative Code §134.203(c)(1)(2), which states "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2015 DWC conversion factor for this service is 56.2. The Medicare Conversion Factor is 35.9335

Review of Box 32 on the CMS-1500 the services were rendered in zip code 79423, which is located in Lubbock, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Rest of Texas."

Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable	Carrier Paid	Amount in Dispute	Due
99204	$159.60	$249.61	$247.70	$247.70	$0.00
95886	$87.29	$136.52 X 2 = $273.04	$271.16	$271.16	$0.00
95910	$188.54	$294.88	$274.38	$274.38	$0.00

Per 28 Texas Administrative Code §134.203 (h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the:

(1) MAR amount;
(2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount or;
(3) fair and reasonable amount consistent with the standards of §134.1 of this title.

The division finds that the insurance carrier paid the amount sought by the requester; as a result, the requestor is not entitled to additional reimbursement for the disputed services identified above.

3. According to the explanation of benefits, the respondent paid $0.00 for HCPCS code A4556 based upon reason code "243."

   HCPCS Code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair."
   Per Medicare guidelines, Transmittal B-03-020, effective February 28, 2003 if Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) HCPCS codes are incidental to the physician service, it is not separately payable. A review of the submitted documentation does not support a separate service to support billing HCPCS code A4556. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		April 7, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.